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May, 1941

BULLETIN OF THE MENNINGER CLINIC

VOLUME 5

NUMBER 3

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Issued bi-monthly by THE MENNINGER CLINIC, TOPEKA, KANSAS
Volumes begin with the January number. Annual subscription rate, $2.00.
Single numbers, 50¢.

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Bulletin of
THE MENNINGER CLINIC

VOLUME 5 MAY, 1941 NUMBER 3

SOME PROBLEMS INVOLVED IN SELECTING AND REARING ADOPTED CHILDREN

BY ROBERT P. KNIGHT, M.D.

Within the past twenty or twenty-five years there have been tremendous changes in the social attitudes and methods regarding children who have lost their parents. This sociological revolution can best be thrown into clear relief by contrasting the former distressing system of "orphan asylums" and haphazard adoptions with the present system of temporary children's institutions, foster homes and child placement agencies with highly trained personnel. The medical, economic and sociological problems involved in child care and placement have been thoroughly studied and written about, but there are still many gaps in the psychiatric illumination of the problems of adoption. This may be partly due to the fact that psychiatrists are not consulted as often as they should be by prospective adoptive parents who presume that anyone can rear a child and that their proffer of a good home for a child is sufficient basis for approval of their request. Also, when the adopted child is not doing well with his new parents, he is often returned to the agency by the disappointed and bewildered couple without benefit of psychiatric study of the disturbing factors in this complicated experiment in which a child who is *really* a "little stranger" tries to live with two adults who are trying to understand, love and rear him.

Nevertheless, the social workers and child placement authorities are well aware of these manifold psychological problems, and the psychiatrist sees and treats enough adopted children in their late teens and early twenties to perceive a number of ordinarily unrecognized factors which play a decisive part in both the actual adoption of the child and his subsequent management. With this justification for a psychiatric discussion of adopt. n problems, let us consider systematically certain pre-adoption and post-adoption problems pertaining to both the adoptive parents and the child they have chosen.

I. PRE-ADOPTION CONSIDERATIONS

A. In regard to the parents

1. Why do the prospective parents not have a child of their own instead of adopting one?

Practically speaking, a married couple does not consider adopting a child unless reasons exist which prevent them from having a child of their own. Sterility in one of them is perhaps the most common cause of childlessness. Aside from the organic sterility produced by surgical removal of a generative organ, natural or artificial menopause through surgery or X-ray or disease, and pathology of the generative apparatus due to mal-development or some disease process, there is a very important kind of sterility of a functional character. The generative organs seem to be normal, but conception does not occur, even though no contraceptive measures are used. Since it is not infrequently happens that a childless wife does become pregnant some time *after adopting a child*, although the adoption did not take place until the couple were thoroughly convinced conception was impossible, one is led to theorize that unconscious opposition to childbearing might have been responsible for the functional sterility, and that this unconscious opposition was somehow overcome by the experience of adopting and taking care of a child. How the unconscious opposition to childbearing might have operated to thwart the conscious attempts to achieve conception is a moot question. One possible hypothesis is that the unconscious of the woman, just as it is known to cause other organ dysfunctions, may affect the physiology of ovulation or implantation in such a way as to prevent conception. Another hypothesis is that there is an unconscious awareness in the woman of the time and fact of ovulation and that she manages to avoid coitus at this critical period, which is the only period (about three days' duration each month) when conception could take place.

Whatever the mechanism of unconscious avoidance of conception, the important factor for our study is the existence of a strong unconscious opposition in the woman to children and childbearing, which opposition is at variance with her consciously professed wishes to have a child. We are all aware of the frequency of *conscious* opposition to having children in married couples so that they take extreme

precautions to avoid conception. This conscious opposition is attributed to convictions that they cannot afford children, that they do not want to have their social life and freedom from responsibility interfered with, and so on. They may even go so far as to express active antagonism to children, referring to them as "brats." In such couples it may happen that after some years they decide to have a child and then find that they cannot bring about conception. The conscious opposition has been changed by considerations such as a realization of the barrenness of their childless home or a growing feeling that the marriage is nearing the rocks and a child is needed to bind them together again. The unconscious opposition, however, has not changed and still operates to prevent pregnancy.

It is obvious that a couple who have but recently changed their attitude in regard to having children are thus open to the suspicion that strong opposition still lingers, and this opposition may be manifested by their prolonged indecision as to just when they will carry out the adoption or by excessively rigid specifications which a prospective adopted child must meet in order to be acceptable to them. It is also logical to assume that such a couple will not be likely to make good foster parents, for they will tend to reject the child if it does not come up to their expectations or if the previously feared loss of freedom and burdensome responsibility actually do occur.

It is not possible within the limits of this paper to discuss all the possible combinations of ambivalent feelings and wishes, conscious and unconscious, in prospective foster parents. It is also evident to the reader that many couples do achieve conception or become the victims of an accidental unwished-for conception who have strong conscious or unconscious opposition to children and childbearing and who, therefore, are not likely to make good parents. This is another problem, however, and a huge one. The point is that adoption agencies have control of the situation and can rule against parents in whom searching interviews reveal the presence of strong negative feelings regarding children.

In general, it may be said that the best foster parents, other factors being equal, will come from those couples in whom the sterility is organic, especially if they desired, had and lost a child prior to the onset of the organic sterility, or those in whom the functional sterility exists in spite of sustained and consistent desire over a period of several

years to have a child, provided the child is not desired merely to help preserve a shaky marriage.

2. Why do the prospective parents want a child of a certain age and of a certain sex?

The search by prospective parents for "a brown-haired, blue-eyed boy aged two and a half with dimples in his cheeks" may be determined by their having had such a child of their own who died, but more often such specific requirements are evidence of the rigid conditions on which they reluctantly lifted their boycott on all children. The insistence on a child's not being younger than a certain age may be evidence of the mother's repulsion regarding toilet training or dirtiness in general in a child, and this is not a good omen for the success of the adoption. It indicates that she will be intolerant of the normal occurrence of dirtiness and messiness in a child, to the emotional detriment of the child.

Sometimes this specifying of exact characteristics is found to be on a narcissistic basis; i.e., the parents wish to find a miniature image of one of them or some combination of them. Parents who have their own blood children obtain this narcissistic satisfaction automatically through the operation of Nature's laws regarding transmission of characteristics, and it might be thought that prospective foster parents are no less entitled to such narcissistic returns. However, the precondition for loving a child which is involved in insistence on certain definite characteristics bodes ill for the future receiving of affection by a child who may almost meet the exact requirements at the time of his selection but who later develops other characteristics which do not suit his new parents.

A healthier attitude, and one which should inspire a more optimistic attitude in the adoption agency, is for the parents to have flexible requirements in regard to age and physical characteristics and insist only on a sound body, normal emotional and intellectual development, and freedom from bad inheritance. The insistence on sex may be inquired into and may have logical reasons behind it or may be determined by neurotic trends in the prospective parents.

B. In regard to the child

There are at least two horns of a dilemma regarding age in adopting a child. If one wishes to adopt an infant and have the opportunity

to rear it from the beginning as if it were one's own, more risk must be taken in regard to its as yet undetermined intelligence potentialities as well as in regard to its future physical development and freedom from abnormalities. The older the child at the time of adoption, the surer one can be of his exact physical and mental status. But these later adoptions sacrifice other values and involve a different set of risks. If prospective parents do not adopt a child until he is four or five years of age, they have lost the chance to be the first parental objects of whom the child was aware and to whom he made his first emotional attachments. He comes to them with comparisons already springing up in myriad respects between his previous "parents" (whatever adults took care of him) and his new adoptive parents. Furthermore, the prospective parents run the risk of having selected a child who has really been traumatized by bad handling prior to the time of adoption. A child who is available for adoption at age four to five very likely has had a somewhat checkered career already, usually before he came into the hands of the adoption agency. A final important risk that needs mentioning is the one pertaining to the feelings of rejection and insecurity arising in the child at the disturbance of his previous home arrangements, even if his condition is greatly improved by the change. Some previous attachments undoubtedly had been made and these must be broken; and a child of four or five is acutely aware of such a change.

It is readily seen that these risks are not present, at least in anything approaching the same degree, if the child is adopted at the age of a few weeks to a few months. The various considerations involved in this particular dilemma together with the prospective parents' preferences and prejudices make the business of selecting a child rather complicated. The best advice, probably, would be for the prospective parents to decide on adopting a very young baby whose background is very well known to the agency, and whose careful examination by a good pediatrician reveals no abnormalities.

II. POST-ADOPTION PROBLEMS

A. The child's awareness of his having been adopted

It is very likely that the child adopted after the age of two will be consciously aware of the change in his home situation. The older he is at the time of adoption, the less likely the chance of his repressing

the memories of the pre-adoption life and the experience of being taken by new parents. Since nearly all experiences of the first two to three years, no matter how severe they may be or how vivid they seem to the child at the time, are later forgotten (infantile amnesia) it is probable that all children adopted early will apparently forget that they were adopted. For this reason as well as because they wish the child to believe he is their own, many foster parents try to keep the fact of adoption concealed from the child at all costs. But just as "murder will out," adoption also will out, for at some time, sooner or later, information filters through to the child via some ill- or well-meaning playmate or adult, and such a discovery is bound to be tremendously unsettling to the child. The parents have a continuous dread, one that subsides and recedes but is never completely absent, that the child may have heard something and is brooding over it. It is a common occurrence for blood children to have phantasies that they are only adopted, and that their "own" parents are wonderfully kind or important people. Such phantasies often occur after the child has been denied something or punished or otherwise frustrated, and he may even express to his parents the idea that he is not really theirs or they would not treat him so badly. Or after hearing that one of his schoolmates is adopted he may come home and ask what that means and then seek reassurance that he is not adopted. Blood parents have no difficulty providing such reassurances, but what of the adoptive parents who have been trying to keep the adoption fact concealed? Without ever having had any real basis for suspecting the fact, their adopted child may have similar phantasies or ask similar questions. To avoid this condition of continuous dread, and especially to avoid the eventuality that the child may discover the fact and confront his parents with it, with resultant loss of faith in their word, it is now generally regarded by all authorities as a much better policy to inform the child that he is adopted.

This still leaves unanswered questions, however; *when* should he be told, and *how*? A child should probably be told he is adopted as soon as he can comprehend the statement. Very likely he will think little of it and forget about it, but as he develops more understanding he should be told several more times until he thoroughly comprehends it. Each time he is told, a little more of the idea is comprehended and more implications are understood and reacted to. To leave the matter

at this, without discussing how the child should be told, would give a false impression, as if the parents were to hammer the information into the child, "rub it in," as it were, to make sure he developed no illusions that he was one of them. This is by no means the idea, of course. The first time the child is told—some time during the fourth year, depending on his intellectual comprehension—he should be told a story about the nice daddy and mother who didn't have any children of their own and who looked and looked for the right one until they found a baby that just suited them; and then they took it home and loved it,—and so on, ending with the statement that they had gotten *him* in that way, too.* Thus the condition of being adopted is made to sound desirable and altogether pleasant. Each subsequent time that the child is told, the same atmosphere should surround the telling, and *under no circumstances, ever,* should the child be reminded that he is adopted when the parent is feeling angry at him. The adoption should *never be mentioned* except as a pleasant matter, and one that the parents are fully satisfied with and have never regretted. No matter how much trouble the child causes, he is always entitled to that minimum feeling of security. For a foster parent to say to an adopted child, "I'm sorry I ever adopted you" is as much of a crime as for a blood parent to say to a child, "I'm sorry you were ever born," or "I wish you were dead."

B. The adopted child's feelings towards his parents

With fortunate circumstances combined with wise handling by the parents an adopted child should grow up with entirely normal feelings and attitudes toward his parents. However, especially if the parents make the serious mistake to be discussed in the next section, there is apt to arise a progressively more difficult complication in the relationship between the child and parents. A child who has learned of his adoption in a traumatic manner, especially if the discovery comes at a time when some feelings of resentment and defiance toward the parents were in the foreground anyway, is very likely to experience a release of hostile feelings toward these parents who have been discovered to be strangers. It is easy for him to re-interpret their disciplinary efforts and their necessarily restrictive and frustrating

*One such story was published under the title "The Chosen Baby" by Dr. Valentina P. Wasson, Carrick and Evans, Inc., N. Y., 1939. There are many others.

management of him as evidence of the fact that they do not and never have loved him and have only been mistreating him in a way his real parents would never have done. With the realization that they are not related to him comes the feeling that he owes them no blood allegiance, and his resentments can expand into ill-concealed or open hostility and defiance.

Such a situation, however, could come about only through gross mishandling of the child and the adoption factor by the parents. One element in mishandling has already been mentioned—the attempt to keep from the child the knowledge that he is adopted, with the almost inevitable result that he discovers it in an emotionally disturbing way from another source and suffers a terrific disillusionment and undermining of his security. Another serious mistake in managing the adopted child which might arouse in him these feelings of hostility and rejection must now be discussed.

C. The parents' feelings toward their adopted child

Every parent who has been through the diverse experiences involved in rearing several children realizes that there are countless times when a child is irritating or annoying in small ways, and a considerable number of times when the child's perverse or anti-social behavior is somewhat alarming. The child's sexual activities may be disturbing or his untruthfulness or dishonesty in matters of money or property may arouse considerable concern. In blood parents such misbehavior does not ordinarily arouse any alarming thoughts about bad inheritance unless the husband or wife should, as sometimes happens, attribute that strain in the child to inherited traits from the "other side of the house."

With adoptive parents, however, the unwelcome idea may all too frequently spring to mind that this distressing behavior of their adopted child is due to bad inheritance. In fact the idea may not be so unwelcome, for it is a convenient method of sparing themselves any self-blame for the child's misbehavior and their own anger about it. They do not realize that their own blood children, had they had some of their own, would have presented problems of the same character and degree, since such behavior—perverse, anti-social, annoying or whatever—is characteristic of childhood at times. So these foster parents, discussing between themselves this supposed "outcropping"

of bad inheritance, may decide that strenuous remedial or disciplinary measures are indicated. These are usually expressions of strong disapproval, marked intolerance of any deviate behavior, severe punishments for transgressions, and a conveying to the child of a strong attitude of rejection, causing him to feel alien and unwanted. His reaction may be to suppress these normal trends and become inhibited and timid in order to achieve approval and feel secure—a neurotic solution, or it may be to burst forth with further acts of defiance, attaching a defiance value to normal perverse or anti-social behavior in the realization that by this method he has the power to disturb and spite his parents. This should be called a delinquent solution.

It is clear that this is a serious pitfall, uncomprehended by many parents of adopted children, who protest that they have always tried to be good parents, to teach and train their child to be honest and upright and moral, and cannot understand how he has turned out so badly unless it is that he had an undetected bad inheritance when they adopted him. All psychiatrists could cite many cases in which exactly these above described child-parent reactions occurred.

DISCUSSION AND SUMMARY

The writer has attempted to explore realistically some of the ordinarily overlooked complicating factors in adopting and rearing children, with the purpose of clarifying such factors in order that parents may better cope with them. The psychiatrist usually sees the adopted children who have been badly handled, and this accounts for the emphasis on negative factors. The tremendous positive values to both the child and his adoptive parents that may and do accrue from adoption probably need no emphasis since there are far more demands for children to adopt than the agencies can fill. The more insidious negative factors do need to be brought to light.

Pre-adoption considerations for prospective parents and adopting agency must include the factor of why the prospective parents want a child, why they have no child of their own, and what their real attitudes are about children. The adoption agency as well as the parents should scrutinize their detailed specifications regarding an acceptable child. The various implications of the age of the child and his previous experiences must be taken into consideration. And after the adoption has been effected, the parents have to be prepared

for some difficulties that are a part of the adoption situation—especially the reactions in themselves and in the child to the knowledge that the child is not their own. They must tell the child early and often, always with pleasurable connotations, that he is adopted; they must be prepared to comprehend with tolerance the child's outbursts of hostility and his various perverse and anti-social acts, realizing that all normal children exhibit these things; they must never express to the child in any way feelings of regret that they adopted him or attribute his misbehavior to his not being their own child; and they must even avoid thinking within themselves that his behavior is alien and attributable to inheritance. Forewarned in these respects, possessed of a natural tolerance and affection for children, there is no reason why foster parents may not successfully rear a child who is not their own.

THE RÔLE OF THE PSYCHOLOGIST IN THE PSYCHIATRIC CLINIC

By J. F. Brown, Ph.D. and David Rapaport, Ph.D.

Until recently the measurement of intelligence, or determination of the intelligence quotient, has been the most important, if not the only, contribution that psychology has made to clinical psychiatry. This has been a valuable contribution, and for many years progressive psychiatric clinics have included a psychometric test as an integral part of the psychiatric examination. This determination has been valuable in evaluating mental deficiency, in determining the presence and degree of deterioration in organic brain diseases, and in estimating the intellectual level of various cases of psychoneurosis or character disorder—an important factor in the prognosis as well as in the therapeutic recommendations. In many psychiatric clinics, the clinical psychologist, if one were indeed available, has functioned largely as a psychometrician or intelligence tester, and has been primarily interested in the cognitive processes of psychiatric patients, leaving the study and evaluation of emotional and motor factors to the psychiatrist.

In the past few years, clinical psychology has been greatly enriched by the development of experimental procedures and personality tests whose results provide valuable data for the examining psychiatrist. There is increasing evidence that this cooperation between psychologist and psychiatrist is becoming more and more fruitful in the direction of developing a more adequate psychology of personality and a more systematic psychopathology[3, 4]. In this paper the authors wish to list and describe the various psychological tests being used in the Menninger Clinic to provide objective outlines of patient's personality for the examining psychiatrists. Some of these tests to be described are fairly well known and are included for the sake of completeness; others, in constant use at this Clinic, are probably unfamiliar to many psychiatrists and psychologists; a few are being used for the first time. The results obtained from these various tests in the studies and research now being conducted will be reported in later papers.

The tests to be described may be classified in four main categories—intelligence tests, projective personality tests, concept formation tests, and tests based on topological psychology. The individual tests in these various groups will be described briefly.

A. INTELLIGENCE TESTS

(1) *The Terman-Merrill Revision of the Stanford-Binet Intelligence Test*[19]. The most widely used intelligence test is the Terman-Merrill revision of the intelligence test first developed by Binet[19]. Although applicable to adults, the test was standardized on children and adolescents. Intelligence quotient and mental age are obtained by the test. The so-called "scatter," the kind and number of problems the patient is unable to solve, has proved in our experience to be of diagnostic importance. The diagnostic indications obtained appeared to agree with the findings of the personality tests and have proved valuable in differential diagnosis of mental delinquency and psychosis as well as of psychoses and neuroses.

(2) *The Cornell-Coxe Performance Test*[7]. This test, the newest of its kind, is a non-verbal test, and hence can be used in cases with speech or language difficulty. It is used to measure practical reasoning and visual-motor coordination and is standardized only on children and adolescents.

(3) *The Bellevue Adult Intelligence Scale*[20]. This test was developed by D. Wechsler, and is the first test standardized on adults. It consists of a verbal and of a non-verbal part, each of which can yield an intelligence quotient; thus, it unites the advantages of the two tests described above. We have found that the "scatter," the numerical relation of the scores of the ten groups of tasks of which the test consists, has diagnostic significance.

(4) *The Minnesota Pre-school Scale*[8]. This test for preschool children fulfills the same needs the Bellevue Test does for adults. It consists of a verbal and of a non-verbal part.

(5) *The Babcock Deterioration Test*[1]. This test contains items similar to those of the Wells Memory Test and the Merrill-Terman Test. Simultaneously with the test, a vocabulary test is given. By a computation based on the assumption that vocabulary deteriorates less than other achievements, a measure of deterioration is obtained. The

test is indicated in organic cases or in cases of differential diagnosis between organic and functional psychoses.

B. PROJECTIVE PERSONALITY TESTS

In the last two decades a new type of testing known as "projective testing" has been developed. In these tests the subject is confronted with unorganized material which he is asked to organize. The methods of organization or the results of it or both are recorded and analyzed. It has been found that such procedures yield material on the basis of which diagnostic indications and personality descriptions of adjusted and maladjusted subjects can be obtained.

Different kinds of such unorganized material have been used for this purpose. The Rorschach Ink-Blot Test, in which the interpretation of ink-blots is the basis of the personality description, is probably the most highly developed of these procedures. Other procedures ask for the creation of stories about pictures, about a given topic, for the recall of childhood stories, for the selection of the most liked and the most disliked of a series of photographs, and other similar tasks.

These procedures have proved clinically to be quite valuable. The degree of reliability, however, varies with each test. The usual standardization procedure of mental tests has not been successfully applied to these, as it is the configuration of factors present rather than the independent quantity of each factor that describes the personality. Broad experience of the psychologist rather than statistically reliable norms is the necessary prerequisite for using these procedures. Serious attempts have been made to validate objectively the diagnostic indications of these tests.

(1) *The Rorschach Test*[2]. This is a semi-directed association test, in which the formal characteristics of the responses (given by the subject to the question of the tester: "What might this be?") to ten ink-blots are interpreted according to experience with the test and psychological theory. The test gives information about cognitive processes in relation to the emotions. The test is indicated where potential intellectual ability, personality description, and clinical diagnosis are in question.

(2) *The Szondi Test*[15]. This is a non-verbal projective personality test based on the choices of the patient from six series of photographs,

each containing eight pictures. (The problem set by the tester is: "Which one do you like most? Dislike most?") Each series shows a homosexual, a sadistic murderer, an epileptic, an hysteric, a catatonic, a paranoiac, a depressive, and a manic. The choices thus obtained allow for interpreting the outstanding character trends and frequently also the diagnostic category of the subject. The test is indicated where personality description, especially differentiation of overt and latent components, is in question.

(3) *Thematic Apperception Test*[12, 13, 18]. This is a test made up of a series of pictures representing scenes. The patient is asked concerning each scene what it represents, how it came about, and what the outcome will be. The test is indicated where it is important to secure material concerning contents and attitudes of patients' phantasies; thus, especially in neurotic and neurotic-psychotic borderline cases.

C. CONCEPT FORMATION TESTS

These procedures attempt to test the ability of the subject to form concepts and the level of concept formation. The impairment of the abstractive and synthetic functions which are implied in concept formation is demonstrated by these tests. Subjects unable to form adequate concepts show performances related to primitive levels in the development of concept formation.

(1) *The Weigl Test*[21]. This test consists of 12 pieces of cardboard, of which four are triangles, four are squares, and four are circles; three of them are green, three are brown, three are red, and three are yellow. The subject is asked to put together the ones which belong together. After he does so, he is asked to make another grouping. This is a test for the most primitive concept formation. It is indicated for children, for deteriorating psychotics, and in cases of organic brain damage.

(2) *The B.R.L. Sorting Test*[21]. This test consists of a number of familiar objects, such as tools, silverware, smoking implements, and the like. The subject is asked to select all the objects belonging with each of six sample objects. Then, twelve groups of objects are shown, and the subject is asked concerning each group: "Why do these belong together?" The procedure tests the ability to form everyday concepts. In our experience, the test has proved to be useful not only in organic and psychotic deterioration, where it is certainly indicated, but also in cases of neurosis.

(3) *The Hanfmann-Kasanin Test*[9, 10]. This test consists of 22 small wooden blocks of five colors, six different shapes, two heights and two widths. The subject has to divide the blocks into four groups. The solution is : (1) high, (2) low, (3) broad, (4) narrow blocks. The test has proved valuable in differential diagnosis of neuroses and psychoses. The individual patterns of solution appear to reveal personality trends.

D. TESTS BASED ON TOPOLOGICAL PSYCHOLOGY

The work of Kurt Lewin in the fields of the psychology of action and affection has great promise for the development of experimental psychopathology. Lewin's ideas of personality structure are, in certain respects, related to those of psychoanalysis. The procedures developed by Lewin and his students may well give us some insight into the dynamics of personality structure as indicated in behavior. Comparison of behavior shown in these experiments with the Rorschach and Szondi tests may uncover significant correlations. These procedures are not yet fully standardized and at present are to be looked upon as of more value for research than for actual practice.

(1) *Modified Dembo Technique*[5, 6]. The test consists of observing the behavior of a subject in a goal-blocked or frustrating situation. After solving a simple problem in two ways, the subject is told that there is a third way—although none exists. Interruptions by the examiner allow observation of the subject and of the persistence he reveals. Also observed are the subject's psychological departures from the situation, the emotional tension developed during frustration, the subject's level of aspiration, and the way this is affected by competition.

(2) *The Level of Aspiration Test*[11]. The test consists of making patterns of increasing difficulty out of colored wooden blocks. The time used for completion of each pattern, i.e. the level of accomplishment, is recorded and compared with the time the subject sets for himself, i.e. the level of aspiration. Faked norms are suggested on some problems in order to measure the effect of competition. The time is adjusted on some problems to assure marked successes and marked failures.

(3) *The Zeigarnik Test*[22, 16]. This test consists of twenty simple tasks, half of which the subject is allowed to finish, the other half of which is interrupted. The normal adjusted person retains the interrupted task better than the completed ones. The ratio of the number

of retained interrupted tasks to the completed tasks varies with the subject. Emotional disturbance, fatigue, lability tend to force this ratio under 1.

PRACTICAL ASPECTS OF ADMINISTERING THE TESTS

The administration of such a comprehensive series of tests requires about twelve hours for testing and six hours for interpreting and reporting. Consequently, only exceptional and research cases are given the whole series. In the routine work at this clinic, adult patients are given: (a) Bellevue Adult Scale, (b) Babcock Deterioration Test, (c) Hanfmann-Kasanin Concept Formation Test, (d) B.R.L. Sorting Test, (e) Rorschach Ink-blot Test, (f) Szondi Test, (g) Thematic Apperception Test. Naturally, in some severe psychotic cases sufficient cooperation is not to be had and the procedure must be modified in that certain tests are omitted. With children and adolescents tests (a) and (b) are omitted and the L-form of the Merrill-Terman Intelligence Test and the Cornell-Coxe Performance Test are substituted. To adolescents test (a) is sometimes administered. With children (d) is omitted and the Weigl Test substituted. With adolescents the latter tests is administered in addition to (c) and (d). To children of pre-school age or to retarded children the Terman-Merrill and the Minnesota Pre-School Tests are administered. The other procedures are administered when they seem specially indicated in clinical or research work.

The routine testing is done during the period of clinical observation and examination of the patient. The results are made available to the examining physician and are included in the case abstract. Use is made of them in diagnosis, prognosis, and recommendations for therapy.

As the original protocols of testing are too bulky, we have found it advantageous to prepare two forms of summary for each test. The first of these attempts in each case to summarize all the pertinent findings and serves as a record for research.* The second attempts to report the findings which are of immediate interest to the physician, who incorporates it in the case abstract.

The following is an example of a summary prepared for the case abstract.

* In succeeding papers we plan to reproduce these various report forms.

Mat 9 (a) SUMMARY OF PSYCHOLOGICAL TESTS

Dr. Rapaport

NAME: *Mrs. B.* AGE: *37 years* DATE: *December 28, 1940*

The tests given describe a person with an I.Q. of 121, a percentile score of 93, putting this patient on the borderline of the bright-normal and superior intelligence groups. Although the scatter does not exceed the range found in neurotics, her judgment, her planning and concentration abilities appear to be quite impaired. Her general mental efficiency appears to be very good. Her learning efficiency is in a childish way all too good. Her motor efficiency is poor and her immediate memory efficiency, although good, remains below her general performance. (Bellevue and Babcock Tests)

The diagnostic personality tests indicate a mixed neurosis with marked psychasthenic and some hysterical features. This neurosis has a circular character. Patient appears to be adaptive on the surface, but extremely narcissistic and autistic in her thinking; she is flighty in her thinking, labile in her mood, poor in her judgment, in spite of an unusually rich natural endowment. She has an unusually vivid fantasy life; many sex preoccupations and general bodily preoccupations are probable. Her aggressions are still fairly well disposed of; her anxieties, free-floating in character, are strong. (Rorschach and Szondi Tests)

The concept formation of this patient appears to be good on the surface, although narrow when she has to make her concepts independently. Her basic concept formation, however, appears to be very much impaired. In spite of a wealth of ideas which she produces toward the solution, she fails to recognize the solution to which she comes near frequently, because of a lack of stability and integrative ability. (B.R.L. Sorting Test and Hanfmann-Kasanin Test)

The fantasies of this patient have much self-reference; in them she describes herself as miserable, hopeless, depressed, and a prospective suicide, who won't be missed by anyone, not even by her children. Life for her is a prison cell without bars; the love of her husband is prison for her, but neither can she stay with her lover and has to return home to be miserable. She sees man and woman in an eternal struggle for domination. The man is dangerous, is about to eat up the woman, to seduce her, to murder her. Besides her husband and her lover, a strict, scolding mother appears twice in the fantasies. Wealth is considered to be the basis of happiness and its lack brings unhappiness, but patient professes to despise the leisurely empty life of the rich. (Thematic Apperception Test)

PERSONALITY AS DESCRIBED BY THE TESTS

The findings of the group of tests present descriptions of different levels of the patient's psychic make up. The intelligence tests reflect the formal achievements of the subject. The concept formation tests investigate the abstractive and synthetic functions and partly also the mode of operation of goal-directed thinking. This

is apparently a more deeply rooted and less arbitrarily segregated part of the personality than the formal intelligence. The Rorschach and Szondi tests reveal certain aspects of the dynamics of the personality and show how the achievement (i.e. the I.Q.) and abstractive and synthetic functions (i.e. concept formation) are related to the dynamics of the personality. The Thematic Apperception Test gives us a sample of the patient's phantasies which reveal further aspects of the personality. The procedures of topological psychology give us some insight into the psychodynamics underlying behavior and memory. Thus a hierarchy of different personality levels is reflected by these tests and procedures.

THE TESTING PROGRAM AND RESEARCH

Although the intelligence tests are well standardized and much experience has been gathered concerning some of the projective tests, their full value for clinical work will not reveal itself before the relation of their findings to the psychiatric findings is better understood. This is one of the research ends pursued with this group of tests. Such research can be well undertaken because of the completeness of psychiatric case studies at the Menninger Clinic.

The use of such a variety of tests offers an opportunity for comparing the results of various tests and for finding the correlations between them. From our present results it would appear that significant correlations would be found.

A further research aim with this group of tests is pursued by follow-up studies of patients treated with different psycho-therapeutic and drug-therapeutic methods. The aim is to establish standards for improvement and for prognosis. The tests are systematically administered before treatments start, at times of important changes in the patient, and before the patient is released. Some reports on this work have already been published[17, 14].

Finally, research with the methods of topological psychology is conducted in an attempt to develop a direct approach to the field of experimental psychopathology. Some reports on this work have also been published[5, 6].

SUMMARY

Recent advances in experimental psychology and the psychology of personality establish the psychologist in a new rôle in clinical psy-

chiatry. Instead of limiting his activities to intelligence testing, the psychologist functions as an investigator of the personality by means of projective personality tests, concept formation tests, Lewinian techniques, and intelligence tests. With his methods he develops criteria for prognosis, for improvement, and, in part, even for therapeutic recommendations. To the clinical methods of the psychiatrist and the psychoanalyst he adds tools having a considerable degree of objectivity in investigating all the aspects of the total personality.

BIBLIOGRAPHY

(1) Babcock, H.: An Experiment in the Measurement of Mental Deterioration. *Arch. Psychol.* 18:105, 1930.

(2) Beck, S. J.: *Introduction to the Rorschach Method. A Manual of Personality Study.* Menasha, Wisconsin. Amer. Orthopsychiat. Assn. Monogr. 1937. No. 1.

(3) Brown, J. F.: Psychoanalysis, Topological Psychology, and Experimental Psychopathology. *Psychoanal. Quart.* 6:227–237, 1937.

(4) Ibid.: *The Psychodynamics of Abnormal Behavior.* New York, McGraw-Hill, 1940.

(5) Ibid.: The Modified Dembo-technique: an Application of Topological Psychology to Experimental Psychopathology. *Bull. Menninger Clinic.* 1:212–219, 1937.

(6) Ibid.: Reactions of Psychiatric Patients in a Frustrating Situation. *Bull. Menninger Clinic.* 3:44–63, 1939.

(7) Cornell-Coxe, E. L., and Warren, W.: *A Performance Ability Scale.* New York, World Book Company, 1934.

(8) Goodenough, F. L., Foster, J. C., and van Wagenen, M. J.: *Minnesota Preschool Scale.* Minneapolis, Educational Test Bureau Inc.

(9) Hanfmann, E., and Kasanin, J.: A Method for the Study of Concept Formation. *J. Psychol.* 3:521, 1936.

(10) Kasanin, J., and Hanfmann, E.: Disturbances in Concept Formation in Schizophrenia. *Arch. of Neurol. & Psychiat.* 40:1276–1282, 1938.

(11) Mahler, W.: Ersatzhandlungen verschiedenen Realitaetsgrades. Untersuchungen zur Handlungs- und Affektpsychologie, XV, ed. by K. Lewin. *Psychol. Forsch.* 18:26–89, 1933.

(12) Masserman, J. H., and Balken, E. R.: The Clinical Application of Phantasy Studies. *J. of Psychol.* 6:81–88, 1938.

(13) Murray, H. A.: *Explorations in Personality.* New York, Oxford Univ. Press, 1938.

(14) Orbison, W. D., Eisner, E., and Rapaport, D.: Psychiatric Implications of Rorschach Studies with Metrazol and Sodium Amytal. Paper read at the 1940 meeting of the American Psychiatric Association, Cincinnati.

(15) Rapaport, D.: The Szondi Test. *Bull. Menninger Clinic.* 5:17–25, 1941.

(16) Ratner, G. A., and Menteschaschwili, I.: Zur Frage der Stoerungen des Behaltens bei progressiven Paralyse. Zugleich ein Beitrag zur Pathologie des Gedaechtnisses. *Monatschr. fuer Psychiat. & Neurol.*, 1929.

(17) Robb, R., Kovitz, B., and Rapaport, D.: Histamine in the treatment of Psychoses. A Psychiatric and Objective Psychological Study. *Am. J. of Psychol.*, 97:601–610, 1940.

(18) Sanford, R. N.: Thematic Apperception Test, directions for Administration and Scoring. Mimeographed manuscript. pp. 47.

(19) Terman, Lewis M., and Merrill, Maud A.: *Measuring Intelligence—A Guide to the Administration of the new revised Stanford-Binet Tests of Intelligence.* New York, Houghton Mifflin Co., 1937.

(20) Wechsler, David: *Measurement of Adult Intelligence.* Baltimore, Williams & Wilkins, 1939.

(21) Weigl, E.: On the Psychology of So-Called Processes of Abstraction. *J. of Abn. and Social Psychol.* 36:3–33, 1941. Translated by Margaret J. Rioch.

(22) Zeigarnik, B.: Ueber das Behalten von erledigten und unerledigten Handlungen. Untersuchungen zur Handlungs— und Affektpsychologie, III., ed. by K. Lewin. *Psychol. Forsch.* 9:1–85, 1927.

THE TREATMENT OF EXHIBITIONISM: AN EXPERIMENT IN COOPERATION BETWEEN POLICE AND PSYCHIATRIC CLINIC

By Daniel Silverman, M.D.*

During the winter of 1939–40 the writer interviewed five young exhibitionists who had been referred by the police. The story of these referrals is itself an interesting one. Exhibitionism had been a vexing problem for the police; jail sentences, fines, public exposure or moralistic lectures did nothing to prevent recidivism. Punishment only caused hardship and disgrace for the exhibitionist, who frequently lost his job and was forced to leave the city. Many times the police were faced with flat denials from the accused, despite substantiation of the charges beyond any reasonable doubt. Friends and relatives, influenced by the exhibitionist's otherwise apparently normal behavior, were willingly enlisted in the defence of his character. Thus the police often unwittingly incurred the intense antagonism of these trusting friends and relatives.

This unfortunate situation was altered by the arrest of one of the cases reported below (X. Y.), who immediately impressed the police with the "medical" aspect of the problem. This man had been fined by the court two years previously, even though he rallied several hundred friends to his defence and exerted considerable pressure on the police for an acquittal. Upon the occasion of the present arrest he cried, asked to be locked up to prevent his "loathsome" behaviour, and begged for a cure; the police authorities appealed to the director of the Municipal Clinics, who referred the case to the writer. Thereafter all cases whom the police believed treatable were referred to the psychiatrist. The other case reported below (A. B. C.) also confessed his misdemeanor to the police, said he had been troubled by these "abnormal desires" for a long time and asked if he could be helped. These two cases will be presented in some detail.

Three of the five cases vigorously denied their guilt, however. All

*Dr. Silverman, formerly a member of the medical staff of the Menninger Clinic and of the Neuropsychiatric Division of the Municipal Clinics where the cases described above were studied, is now a member of the psychiatric staff of the Medical Center for Federal Prisoners (United States Public Health Service, Reserve).

constructed the same circumstantial rationalization—a sudden urge to urinate—to explain away their arrests for indecent exposure. No matter how damaging was the evidence or how absurd the accused's defense, each clung to his denial tenaciously. One, a surly, somewhat schizoid man of 28, was seen several times in the exhibitionistic act only one block from his home. Yet he angrily assured the writer that this was a police "frame-up" and rejected violently the idea that he might be abnormal. He declared that he was no "sex maniac" because he rarely had intercourse even with his wife! His older brother, who accompanied him, threatened the writer with legal action for assuming the patient's guilt. Doubt as to his brother's innocence grew only after confronted with the evidence of the police.

Another, an effeminate, immaculately dressed 25 year old married man, who had been driving around the residential district of the city from 8:00 to 10:00 p.m., got out of his car, completely lowered his trousers and "urinated" in front of an open window of his accuser's house. Although this was only five minutes drive from his own home, he insisted that micturition was the only reason for exposing his genitalia. He tacitly admitted guilt by claiming that, if he *were* an exhibitionist, he certainly could control himself by "will-power" and would not need any treatment. The third exhibitionist, a passive 22 year old boy, exclaimed, almost at the point of tears, that it would be stupid of him to jeopardize the security of his home by such an act, especially with a new-born son in the family. His mother called the writer and begged him to "clear" her son's name. Yet this man, like the others, refused the offer of psychiatric help and chose to undergo a public trial, which in his case resulted in exposure, a fine, the loss of his job and the necessity of leaving the city because of the scandal.

CASE REPORTS

Case 1: A. B. C., age 36, married, was arrested for indecent exposure on the complaint of two school girls who had obtained his automobile license number after seeing him open the door of his car, exhibit his penis and masturbate. The writer was called to the police station to interview the patient. He was a handsome, neatly dressed man—tense, subdued and mildly depressed. He stated that he couldn't get "sex" out of his mind and for years had wanted to be "cured" of his abnormality but feared that it was impossible and that he would "go insane" or kill himself. He never knew where or to whom to turn

for help. When the psychiatric attitude toward his problem was explained and when a course of examination and treatment was suggested, he felt greatly relieved and eagerly accepted the outlined plan. He assured the writer that he was sincere in his desire for treatment. No criminal charges were preferred in his case.

History: Exhibitionism had begun at the age of 29. He usually awaited the moment when it would be "safe" to open the door of his car and expose his genitalia. He watched the faces of the victims searchingly for signs of favorable reaction, but never approached them. If he thought the reaction was favorable, this would excite him to imagine the victim exposing her genitalia and the events leading up to coitus. Then he would masturbate. He usually recognized beforehand the days when he would exhibit himself by a sense of expectation and exhilaration. He knew it was "wrong and silly", but much as he struggled, he could not prevent it. Afterwards he would feel extremely guilty, depressed and ashamed of his behavior. For the previous month he had been "attracted" to an adolescent girl and would once or twice weekly drive by her school at closing hour to exhibit himself. He was detected when two other girls accidentally saw him.

The patient was the third of six siblings, two boys and four girls. His only brother, eight years older than the patient, left home when the patient was eight; he had teased the patient unmercifully. All siblings were well adjusted and married. His father, 68, was even-tempered but stern; his mother, 65, loving and overindulgent. He remembered nothing unusual about his childhood, which was spent in a nearby small town, except an unreasoning fear of his father. There had been strict rules against nudity in the home. In adolescence he began masturbating and worried what other people would think of him "if they knew". When in high school he was very shy of girls, felt inferior and was consumed with a desire to see female genitalia. At eighteen he left home, worked in large cities, and 13 years ago (age 23) obtained his present job as a bookkeeper in a wholesale house. His first sexual experience was with a prostitute when he was 22. He married at the age of 26 after a three year courtship. Within a short time he had a recurrence of his "peeping" desires, excited by a neighborhood woman who provocatively undressed in front of an open window. Soon he engaged in an extra-marital affair which lasted three years. After this affair terminated, he was obsessed with the wish for intercourse with women other than his wife, but "did not have the nerve" to approach them. Every time he looked at a strange woman, he viewed her as a prospective conquest. He was invariably attracted to young girls, whom he would picture naked and with whom he would fantasy having intercourse. When he rode alone in his car he would masturbate. Then he began to exhibit himself as related above.

Examination: The patient was friendly and cooperative in the examinational procedures. He was well developed, of average height and weight. Physical and laboratory findings were normal; his intelligence was average. There were no psychotic manifestations. He told the above story hesitantly, without verbosity or circumstantiality; some of the details, for example his voyeurism, were not revealed for several weeks. He had few friends and no outside interests. He was extremely neat and orderly in all his habits. All of his actions were pervaded with a certain passivity. His only difficulties, he said, were exhibitionism, masturbation and obsessive thoughts of sexuality. Insight was limited to the recognition that he was abnormal.

Course: Except for the first week when he was seen three times, the patient came to the clinic weekly for the next three months for psychotherapeutic conferences lasting from one-half to one hour. There was no compulsion to attend either from the police or the therapist, and the secret of his abnormality was not revealed to his wife or others. The patient kept all his appointments punctually. The first sessions were purely anamnestic and he obtained considerable relief from revealing his sexual deviations to a sympathetic listener. He said this was the first time he had been able to talk to anyone about his troubles. This lessened his tension to a point where he did not feel strong exhibitionistic desires and could exercise control over them. A strong positive transference became evident, but the further back chronologically he went in discussing his exhibitionism and early sexual experiences, the more resistance was encountered and the less material was brought forth. He accepted the therapist's suggestion that childhood influences and interpersonal relationships may have laid the setting for his difficulty, but he could recall nothing more than what he had told. He was repeatedly asked for dreams, and their value was explained to him, but he remembered none.

Investigation was shifted to his marital relationship, which at first he said was wholly satisfactory. He was asked to describe his wife and how they got along. His wife, an attractive buxom woman two years his junior, was an obstinate and domineering person. He said he loved her and could "imagine no better woman for my wife". She mothered him, petted him, looked out for his every need and made him very dependent on her. When he came home she would sit on his lap and her breasts would excite him sexually so that he could think only of intercourse. But, he admitted, they argued incessantly about "petty" matters, each too stubborn to give in to the other. When pressed for examples, he hesitated to speak at first, but then launched into an account of their difficulties. Should he arrive home a few minutes late, she would be overly suspicious and demand an accurate accounting of every moment from the time he left his work until he arrived at home. She "nagged" him, hampered his freedom by concentrating all her attention on him when he was home. Because of

these continual arguments he had thought of separation. It was explained that disagreements of this sort usually indicated deeper dissatisfactions on both sides and that hostile feelings could be expected in any marriage. At first he denied that there was anything more to it than "jealousy". Later he recalled a conscious resentment he bore against his wife before their marriage. During courtship they "petted" violently, but she had refused to have pre-marital intercourse. Often he had to masturbate or go to prostitutes for relief. But, he said, his resentment did not remain after marriage. Then, he revealed, intercourse was not satisfactory for him; he had premature ejaculations. She became more aggressive sexually and assumed the masculine position. Often he did not satisfy her and then she would accuse him of infidelity, which he denied. He said his wife planted the idea of an extra-marital affair in his mind by her frequent accusations. She chided him also about his not wanting children. It was pointed out that his wife's irritating ways might be due to her lack of sexual satisfaction. Perhaps, it was suggested, he had allowed himself to become too passive with her; maybe sexual thoughts plagued him because, as he said, he "didn't have enough nerve".

Soon he reported that their relationship was improving—they did not fight as much and he had begun to take the active coital rôle. He assumed much of the blame for their disagreements and said his wife was more satisfied and happier than ever before. Masturbation ceased and he asked for advice to facilitate pregnancy (surgical procedures on his wife were needed). He was much encouraged when his exhibitionistic and peeping desires disappeared. Later he concluded that he had suffered from an exaggerated "inferiority complex" and that his exhibitionism was a desire to prove his masculinity to others in a childish way. His whole life had changed, he claimed. He felt more confidence in himself, was able to concentrate on his work, to feel at ease with people. He was discharged from the clinic, with the advice to return if he felt the need for further treatment.

Six months later he was requested to return for follow-up and was interviewed by another member of the staff. He had remained free from exhibitionism, although an occasional temptation, which aroused no anxiety and was easily dismissed, had occurred. His state of well-being was maintained. He said he had been helped "a lot". His insight seemed highly intellectualized but afforded a good social adjustment.

Comment: In this case the etiologic factors were not clearly definitive, because insufficient relevant data about the patient's childhood were obtained. However, discussions of the precipitating factor (marital maladjustment) revealed that his wife had emasculated this already passive, somewhat "castrated" patient, forcing him into an infantile

dependent role (which he partly desired) and arousing both hostility and anxiety. These conflicts resulted not only in fights with his wife, but also in defiance, evidenced by extra-marital relationships and later when his passivity increased, by genital exposure to others. Relief of anxieties and insight into his marital relationship allowed the patient to express his masculinity in a more mature manner and eliminated the compulsive need for exhibiting his genitalia. It is not suggested that the underlying neurotic conflict of this patient was resolved and that he was "cured". However, the acuteness of his problem certainly was lessened and brought under control and he attained sufficient insight to permit a much better social adjustment.

Case 2: X. Y., 39 years old, was arrested on the complaint of several women who had seen him exhibit himself and who had reported his automobile license number. The writer was called to interview the patient at the police station. He was a thin, well-built, plain-featured man of average height. He seemed subdued, meek and tearful. He begged for help, said he would do anything to rid himself of this "curse" and readily agreed to undergo treatment at the clinic. The police obtained a continuance of his case from the court, pending treatment, but released the psychiatrist from responsibility for possible subsequent offenses.

History: The patient first exposed his genitalia to girls at the age of 10, shortly after the birth of a brother and after he had been introduced to masturbation by an older neighborhood boy. Since then he had an uncontrollable exhibitionistic desire once or twice a month. The desire was preceded by prodromes—a sense of exhilaration, of nervousness and cardiac palpitation. He would feel it coming, resolve not to give in to it, yet know that eventually he would. The struggle in his mind would be intense. When the opportunity came, he would throw caution to the winds and, as though in a "trance", unbutton his trousers and exhibit his penis without caring about the consequences. He had no conscious desire to attract the attention of his victims, to talk to them or to touch them. Often he did not care if they actually saw him. They were always unknown women of varying ages. Frequently the act was part of a masturbatory experience; i.e., he would begin masturbation before and ejaculate during or after the act. Sometimes he had no erection during the exhibitionism. Afterwards he felt a relief of tension, but remorse and guilt for his "immoral act". The only way to forestall his exhibitionism was to have some intimate, e.g., his wife, with him. Since owning a car during the past seven years, his "attacks" had been increasingly frequent and had occurred exclusively when he was alone in the car.

In that time the patient had been arrested four times, but it was only on the present offense that he pleaded guilty.

The patient was the sixth of ten siblings, seven girls and three boys; he was the first boy. Two children following him were girls so that he was the only boy until he was ten. His father was an elderly mild-mannered man and his mother was very "strict". He was greatly indulged as a child. Nudity was absolutely forbidden in the household and the mother allowed no one but herself to dress and bathe the patient. At six he was caught "peeping" at his sisters who were taking a bath and for this he was soundly beaten. Nevertheless his voyeurism persisted throughout childhood. He attended rural schools and worked on the farm until the family moved to the city when he was about twenty years old. He learned the baking trade and had since been employed in this work. His first heterosexual contact was at the age of 17, and his sexual experiences were infrequent thereafter until his marriage at the age of 26. The marriage was declared to be a happy one. Two children were born, both girls now in their teens. For the past ten years coitus interruptus had been practiced, because pregnancy would have endangered his wife's life.

Examination: Physical examination and laboratory findings were normal. The Rorschach test indicated anxiety, mild depression and severe conflict regarding sexuality in a subject of average intelligence. There were no psychotic manifestations. He related the above story in short, hesitant sentences and required considerable encouragement and prompting. He admitted that he had a severe conflict over masturbation which he felt compelled to do once or twice weekly and that sexual relations with his wife were only partly satisfactory due to the coitus interruptus. Otherwise his life was happy; he loved his wife and children, had an intimate circle of friends, enjoyed his work and spent much of his spare time working at his hobby of leather working in his own work-shop at home. He was extremely meticulous about his work, cleanly in his habits and set a high moral standard for himself. It was apparent from his non-committal or perfunctory expressions that his interpersonal relationships were not warm but rather quite compulsive.

Course. The patient started daily psychotherapeutic interviews with another member of the staff. As an initial precautionary measure it was arranged that his wife was to accompany him at all times in his car. There were no episodes of exhibitionism during the period of this patient's special psychotherapy. He continued to be accompanied by his wife or brother except while he was at home or at work. He evinced little real interest in the psychotherapeutic task and produced no material of dynamic significance. After several weeks the patient broke off treatment without explanation. Later it was learned that this action had directly followed the dismissal of his case by the court.

Comment: The psychodynamics of exhibitionism in this patient were speculative, but certain factors in his history were clearly significant. Being surrounded by so many doting women as a child probably developed strong narcissistic trends in him, and the absence of men (except for an elderly, weak father) together with strict taboos against nudity and severe punishments by his mother for "peeping" induced strong castration fears. The birth of a male rival and perhaps a traumatic experience with an older boy precipitated this symbolic denial of castration and infantile method of showing-off. The neurotic conflict was so violent that during the compulsive act he passed into an almost dissociated hysterical state. Probably his tremendous anxieties contributed to his breaking off the treatment as soon as the legal threat was removed. However it is believed that the patient profited from the incomplete therapy; he was afforded some relief through catharsis, a plan for his protection had been worked out, and mental hygiene advice, such as contraceptive measures, had been given. In the year that has passed since he was last seen by a psychiatrist, he has not been reported to the police.

DISCUSSION

Exhibitionism has occurred as a symptom in almost every psychiatric condition—psychoses, psychoneuroses, intoxicated states, mental deficiencies, psychopathic personalities, and organic brain diseases. In a recent series of cases, Henninger* found 19 out of 51 to be without any other classifiable disorder and called these the "emotionally unstable" group. It was significant that all of this group were men and all showed heterosexual immaturity, feelings of inferiority and lack of normal aggressiveness.

It was within this group that the cases described in this paper fell. All the features mentioned by Henninger were found in these patients. They were passive, compulsive, reticent, somewhat schizoid persons. They did not realize why they were impelled to expose themselves and never were proud of it. Their moral standards were strict and the conflict over their behaviour so severe that they would go to extremes to deny the disorder. For this reason, treatment was often impossible, unless good rapport could be obtained from the start.

*Henninger, James M: Exhibitionism. *J. Crim. Psychopath.*, 2: 357–66, 1941.

The practical demonstration of the psychiatrist's usefulness to the police does more to promote better relations between the court and psychiatrist than theoretical discussions. Such experiences as related in this paper encourage a psychiatric attitude in those dealing with psychopathic offenders. In this city the local authorities now give the exhibitionist an opportunity to interview a psychiatrist before formal charges are filed and if therapy is thought feasible, the case is dismissed as far as the court is concerned. In this manner maximum rapport between patient and psychiatrist is established. Case 1 illustrates the possibilities for effective therapy within the scope of City Clinic practice and indicates that in some cases thorough-going psychoanalysis is not necessary. Psychotherapy directed toward related though more superficial conflicts may reestablish the patient's inner psychic equilibrium and result in a social recovery.

Examination: The patient was friendly and cooperative in the examinational procedures. He was well developed, of average height and weight. Physical and laboratory findings were normal; his intelligence was average. There were no psychotic manifestations. He told the above story hesitantly, without verbosity or circumstantiality; some of the details, for example his voyeurism, were not revealed for several weeks. He had few friends and no outside interests. He was extremely neat and orderly in all his habits. All of his actions were pervaded with a certain passivity. His only difficulties, he said, were exhibitionism, masturbation and obsessive thoughts of sexuality. Insight was limited to the recognition that he was abnormal.

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these continual arguments he had thought of separation. It was explained that disagreements of this sort usually indicated deeper dissatisfactions on both sides and that hostile feelings could be expected in any marriage. At first he denied that there was anything more to it than "jealousy". Later he recalled a conscious resentment he bore against his wife before their marriage. During courtship they "petted" violently, but she had refused to have pre-marital intercourse. Often he had to masturbate or go to prostitutes for relief. But, he said, his resentment did not remain after marriage. Then, he revealed, intercourse was not satisfactory for him; he had premature ejaculations. She became more aggressive sexually and assumed the masculine position. Often he did not satisfy her and then she would accuse him of infidelity, which he denied. He said his wife planted the idea of an extra-marital affair in his mind by her frequent accusations. She chided him also about his not wanting children. It was pointed out that his wife's irritating ways might be due to her lack of sexual satisfaction. Perhaps, it was suggested, he had allowed himself to become too passive with her; maybe sexual thoughts plagued him because, as he said, he "didn't have enough nerve".

Soon he reported that their relationship was improving—they did not fight as much and he had begun to take the active coital rôle. He assumed much of the blame for their disagreements and said his wife was more satisfied and happier than ever before. Masturbation ceased and he asked for advice to facilitate pregnancy (surgical procedures on his wife were needed). He was much encouraged when his exhibitionistic and peeping desires disappeared. Later he concluded that he had suffered from an exaggerated "inferiority complex" and that his exhibitionism was a desire to prove his masculinity to others in a childish way. His whole life had changed, he claimed. He felt more confidence in himself, was able to concentrate on his work, to feel at ease with people. He was discharged from the clinic, with the advice to return if he felt the need for further treatment.

Six months later he was requested to return for follow-up and was interviewed by another member of the staff. He had remained free from exhibitionism, although an occasional temptation, which aroused no anxiety and was easily dismissed, had occurred. His state of well-being was maintained. He said he had been helped "a lot". His insight seemed highly intellectualized but afforded a good social adjustment.

Comment: In this case the etiologic factors were not clearly definitive, because insufficient relevant data about the patient's childhood were obtained. However, discussions of the precipitating factor (marital maladjustment) revealed that his wife had emasculated this already passive, somewhat "castrated" patient, forcing him into an infantile

dependent role (which he partly desired) and arousing both hostility and anxiety. These conflicts resulted not only in fights with his wife, but also in defiance, evidenced by extra-marital relationships and later when his passivity increased, by genital exposure to others. Relief of anxieties and insight into his marital relationship allowed the patient to express his masculinity in a more mature manner and eliminated the compulsive need for exhibiting his genitalia. It is not suggested that the underlying neurotic conflict of this patient was resolved and that he was "cured". However, the acuteness of his problem certainly was lessened and brought under control and he attained sufficient insight to permit a much better social adjustment.

Case 2: X. Y., 39 years old, was arrested on the complaint of several women who had seen him exhibit himself and who had reported his automobile license number. The writer was called to interview the patient at the police station. He was a thin, well-built, plain-featured man of average height. He seemed subdued, meek and tearful. He begged for help, said he would do anything to rid himself of this "curse" and readily agreed to undergo treatment at the clinic. The police obtained a continuance of his case from the court, pending treatment, but released the psychiatrist from responsibility for possible subsequent offenses.

History: The patient first exposed his genitalia to girls at the age of 10, shortly after the birth of a brother and after he had been introduced to masturbation by an older neighborhood boy. Since then he had an uncontrollable exhibitionistic desire once or twice a month. The desire was preceded by prodromes—a sense of exhilaration, of nervousness and cardiac palpitation. He would feel it coming, resolve not to give in to it, yet know that eventually he would. The struggle in his mind would be intense. When the opportunity came, he would throw caution to the winds and, as though in a "trance", unbutton his trousers and exhibit his penis without caring about the consequences. He had no conscious desire to attract the attention of his victims, to talk to them or to touch them. Often he did not care if they actually saw him. They were always unknown women of varying ages. Frequently the act was part of a masturbatory experience; i.e., he would begin masturbation before and ejaculate during or after the act. Sometimes he had no erection during the exhibitionism. Afterwards he felt a relief of tension, but remorse and guilt for his "immoral act". The only way to forestall his exhibitionism was to have some intimate, e.g., his wife, with him. Since owning a car during the past seven years, his "attacks" had been increasingly frequent and had occurred exclusively when he was alone in the car.

In that time the patient had been arrested four times, but it was only on the present offense that he pleaded guilty.

The patient was the sixth of ten siblings, seven girls and three boys; he was the first boy. Two children following him were girls so that he was the only boy until he was ten. His father was an elderly mild-mannered man and his mother was very "strict". He was greatly indulged as a child. Nudity was absolutely forbidden in the household and the mother allowed no one but herself to dress and bathe the patient. At six he was caught "peeping" at his sisters who were taking a bath and for this he was soundly beaten. Nevertheless his voyeurism persisted throughout childhood. He attended rural schools and worked on the farm until the family moved to the city when he was about twenty years old. He learned the baking trade and had since been employed in this work. His first heterosexual contact was at the age of 17, and his sexual experiences were infrequent thereafter until his marriage at the age of 26. The marriage was declared to be a happy one. Two children were born, both girls now in their teens. For the past ten years coitus interruptus had been practiced, because pregnancy would have endangered his wife's life.

Examination: Physical examination and laboratory findings were normal. The Rorschach test indicated anxiety, mild depression and severe conflict regarding sexuality in a subject of average intelligence. There were no psychotic manifestations. He related the above story in short, hesitant sentences and required considerable encouragement and prompting. He admitted that he had a severe conflict over masturbation which he felt compelled to do once or twice weekly and that sexual relations with his wife were only partly satisfactory due to the coitus interruptus. Otherwise his life was happy; he loved his wife and children, had an intimate circle of friends, enjoyed his work and spent much of his spare time working at his hobby of leather working in his own work-shop at home. He was extremely meticulous about his work, cleanly in his habits and set a high moral standard for himself. It was apparent from his non-committal or perfunctory expressions that his interpersonal relationships were not warm but rather quite compulsive.

Course. The patient started daily psychotherapeutic interviews with another member of the staff. As an initial precautionary measure it was arranged that his wife was to accompany him at all times in his car. There were no episodes of exhibitionism during the period of this patient's special psychotherapy. He continued to be accompanied by his wife or brother except while he was at home or at work. He evinced little real interest in the psychotherapeutic task and produced no material of dynamic significance. After several weeks the patient broke off treatment without explanation. Later it was learned that this action had directly followed the dismissal of his case by the court.

Comment: The psychodynamics of exhibitionism in this patient were speculative, but certain factors in his history were clearly significant. Being surrounded by so many doting women as a child probably developed strong narcissistic trends in him, and the absence of men (except for an elderly, weak father) together with strict taboos against nudity and severe punishments by his mother for "peeping" induced strong castration fears. The birth of a male rival and perhaps a traumatic experience with an older boy precipitated this symbolic denial of castration and infantile method of showing-off. The neurotic conflict was so violent that during the compulsive act he passed into an almost dissociated hysterical state. Probably his tremendous anxieties contributed to his breaking off the treatment as soon as the legal threat was removed. However it is believed that the patient profited from the incomplete therapy; he was afforded some relief through catharsis, a plan for his protection had been worked out, and mental hygiene advice, such as contraceptive measures, had been given. In the year that has passed since he was last seen by a psychiatrist, he has not been reported to the police.

DISCUSSION

Exhibitionism has occurred as a symptom in almost every psychiatric condition—psychoses, psychoneuroses, intoxicated states, mental deficiencies, psychopathic personalities, and organic brain diseases. In a recent series of cases, Henninger* found 19 out of 51 to be without any other classifiable disorder and called these the "emotionally unstable" group. It was significant that all of this group were men and all showed heterosexual immaturity, feelings of inferiority and lack of normal aggressiveness.

It was within this group that the cases described in this paper fell. All the features mentioned by Henninger were found in these patients. They were passive, compulsive, reticent, somewhat schizoid persons. They did not realize why they were impelled to expose themselves and never were proud of it. Their moral standards were strict and the conflict over their behaviour so severe that they would go to extremes to deny the disorder. For this reason, treatment was often impossible, unless good rapport could be obtained from the start.

*Henninger, James M: Exhibitionism. *J. Crim. Psychopath.*, 2: 357–66, 1941.

The practical demonstration of the psychiatrist's usefulness to the police does more to promote better relations between the court and psychiatrist than theoretical discussions. Such experiences as related in this paper encourage a psychiatric attitude in those dealing with psychopathic offenders. In this city the local authorities now give the exhibitionist an opportunity to interview a psychiatrist before formal charges are filed and if therapy is thought feasible, the case is dismissed as far as the court is concerned. In this manner maximum rapport between patient and psychiatrist is established. Case 1 illustrates the possibilities for effective therapy within the scope of City Clinic practice and indicates that in some cases thorough-going psychoanalysis is not necessary. Psychotherapy directed toward related though more superficial conflicts may reestablish the patient's inner psychic equilibrium and result in a social recovery.

BOOK NOTICES

Emotion and Conduct in Adolescence. By CAROLINE B. ZACHRY, PH.D. Price $3. Pp. 563. New York, D. Appleton-Century Co., 1940.

The Progressive Education Association appointed a Commission on the Secondary School Curriculum which devoted itself to a study of adolescents in order to gain a better understanding of the adolescent and his educational needs. This is the first published account of some of the work done by this Commission in the past five years. It is a systematic discussion of the psychological problems of the adolescent, considered with respect to his changing attitudes toward himself, toward others, and toward social institutions by a highly competent authority. It is clearly written, and profusely illustrated with well summarized case material. In the selected readings, this reviewer would suggest the addition of Anna Freud's *The Ego and the Mechanisms of Defense*, the last two chapters of which deal with adolescence. (K. A. M.)

The Patient's Dilemma. By HUGH CABOT, M.D. Price $2.50. Pp. 284. New York, Reynal & Hitchcock, 1940.

Cabot brings the combined experience of general surgeon, dean, and urologist at the Mayo Clinic to this study of the chaos of medical care in the United States. The "patient's dilemma" is also the "doctor's dilemma"; modern medicine is too complex for the old "family doctor" who is already a relic of the past. For a variety of reasons—scientific, economic, and even moral—good medical care, Cabot holds, can be provided only by groups of specialists and general practitioners working in conjunction with modern hospitals or clinics. Cabot presents a set of blueprints for the future of medicine, which should be studied by doctors, public health experts, social security planners, and social workers. (D. W. O.)

The Hopi Child. By WAYNE DENNIS. Price $2.50. Pp. 204. New York, D. Appleton-Century Co., 1940.

Here is a book which is essentially sociological in nature, written as if it were an anthropological study, by a man who is an assistant professor of psychology. It is a careful description of the various features and phases of the life of the children in the remote Pueblo tribe known as the Hopi in northern Arizona.

The style is simple, clear and interesting, although inclined to be prudish in spots. All in all, it is an unusually interesting scientific book which all of those working in child psychiatry would profit by reading. (K. A. M.)

Social Psychology. By CHARLES BIRD. Price $3.50. Pp. 364. New York, D. Appleton-Century Co., 1940.

This most recent text of social psychology is written from the point of view of academic social psychology with some, but insufficient reference, to sociology and social anthropology. The attempt is made to integrate all the recent researches, particularly the experimental researches, into one volume. This results in a book which presents a vast amount of precise material, the implications of which are rarely clear and often meaningless. Neither the topological nor the psychoanalytic approaches receive any attention whatsoever. (J. F. B.)

The Sexual Perversions and Abnormalities. By CLIFFORD ALLEN, M.D. Pp. 193. London, Oxford Medical Publications, 1940.

This is a systematic, didactic account of the various forms of sexual perversion, written with clarity and a complete absence of the sensationalism which often appears even in scientific treatises. The author begins with the natural history of the instincts, showing where, how, and why they become deflected to pathological aims or modes. The comparisons with phenomena in animals is particularly interesting. (K. A. M.)

The Structural Changes Produced in the Human Brain by Oxygen Deprivation (Anoxemia) and Their Pathogenesis. By JOHN CHORNYAK. Pp. 77. Ann Arbor, Edwards Brothers, Inc., 1938.

The clear delineation of the pathophysiology of anoxemia and a lucid description of the ensuing structural changes presented in this monograph make it a splendid contribution to formal neuropathology. Whether the implications of this study for psychology and psychiatry are as basic as Hoskins in his foreword indicates that they might be, still remains to be seen. (N. R.)

Psychotherapy. By LEWELLYS F. BARKER, M.D. Price $2.00. Pp. 218. New York, D. Appleton-Century Co., 1940.

In view of the fact that fifty per cent of the patients consulting physicians are reported to be psychiatric rather than organic problems, it is appropriate that Dr. Barker, with his notable record for catholicity and clinical skill, should summarize his conceptions of psychotherapy. In surprisingly compact form he has reviewed numerous psychotherapeutic methods, including psychoanalysis (about which, however, he has some misgivings). The fact that an internist of his experience should realize the necessity of such a book is an indication of the current trend of medical thought. (K. A. M.)